IP.1 - Information Profile

Name:	**Date:** Be certain to change date to date of planning mtg.	
Address:	**Sex:** Select	
City/Zip: ,	**DOB:**	
Phone: ( ) -	**DDS#:**	
Type of Residence: Select	**Primary language:** English	**Ethnicity:** Select
Allergies:	**Communication Style:** Select	

Case Manager (CM):	**CM Phone: ( ) -**	
Level of MR: Select	**Diagnosis:**	**ICD 9 codes**:
Legal Status: Select	**Type of Waiver:** Select	
Registered Voter: Select	**Waiver Enrollment Date:**	
Residential WL: ☐ **Priority Status:**	**Day WL:** ☐ **Priority Status:**	
WL Referral Date:	**WL Referral Date:**	

1. Have there been any changes in addresses or contact information about you, your guardian, primary responsible person, or other contact people? What is the current information?
2. Have any of your support providers changed? What is their contact information?
3. Does my residence and employment/retirement/day or other support service providers know who my DDS case manager is?

Guardian: Select		
Name:	**Home: ( ) -**	**Cell: ( ) -**
Address:	**Email: @ .** Ask if this can be shared with CO for mailings.	
Primary Responsible Person **Look in Ecamris to identify. This is the PRRP in CAMRIS, not a provider.**		
Name:	**Home: ( ) -**	**Cell: ( ) -**
Relationship:	**Email: @ .** Ask if can be share with CO.	
Address:		
Emergency Contact (stand by if PRP is not available) **As designated by the PRP**		
Name:	**Home: ( ) -**	**Cell: ( ) -**
Address:	**Email: @ .**	
Conservator		
Name:	**Home: ( ) -**	**Cell: ( ) -**
Address:	**Email: @ .**	

Medical Contacts:

Physician:	**Phone: ( ) -**	**Fax: ( ) -**
Dentist:	**Phone: ( ) -**	**Fax: ( ) -**
Other:	**Phone: ( ) -**	**Fax: ( ) -**
Other:	**Phone: ( ) -**	**Fax: ( ) -**

Provider Agency Contacts		
Residential:	**Phone: ( ) -**	**Fax: ( ) -**
Contact/Title: ,		**Email: @ .**
Day:	**Phone: ( ) -**	**Fax: ( ) -**
Contact/Title: ,		**Email: @ .**
Fiscal Intermediary:	**Phone: ( ) -**	**Fax: ( ) -**
Contact/Title: ,		**Email: @ .**
DSS:	**Phone: ( ) -**	**Fax: ( ) -**
Contact/Title: ,		**Email: @ .**
SSI:	**Phone: ( ) -**	**Fax: ( ) -**
Contact/Title: ,		**Email: @ .**
Other:	**Phone: ( ) -**	**Fax: ( ) -**
Contact/Title: ,		**Email: @ .**

1. Have you submitted a Medicaid application or redetermination recently?
2. What are the current amounts of your wages, savings, checking, and entitlement income?
3. Have any of your insurance identification numbers changed?
4. Do you have a trust fund?
5. **Get as much information about benefits as possible.**

Resource and Benefit information (*Check all that apply*) Fill out as completely as possible

Medicaid Application/Redetermination Current ☐ Yes Last Redetermination Date: / /Mandatory		
☐ **Earned Income – Monthly $**	☐ **Prepaid Funeral Plan**	☐ **Health Insurance#**
☐ **Savings Balance $**	☐ **Prepaid Burial Plan**	☐ **Railroad Insurance#**
☐ **SSI# - - Month $**	☐ **Title XIX #**	☐ **Medicare A#**
☐ **SSDI# Monthly $**	☐ **DSS Cash Assistance $**	☐ **Medicare B#**
☐ **Checking Balance $**	☐ **Food Stamps Monthly$**	☐ **Medicare D#**
☐ **Trust Fund $**	☐ **Other:**	☐ **Other:**

1. What are the supports you receive from DDS?
2. Do you self-direct your supports or use a qualified provider? Or are your supports paid by contract?

DDS Support Information

☐ **CM**			☐ **TCM**		
☐ **Residential**	☐ **Self Direct**	☐ **Vendor**	☐ **Master Contract**	☐ **Public**	☐ **Other**
☐ **Day/Employment**	☐ **Self Direct**	☐ **Vendor**	☐ **Master Contract**	☐ **Public**	☐ **Other**
☐ **Individual and Family Grant**		**Need Level:**	☐ **Low** ☐ **Med**	☐ **High**	**Amount**
☐ **Respite Center**			☐ **Rent Subsidy Monthly:**		
☐ **IFS Resource Support Team**			☐ **Other**		

1. Has information about your rights been shared with you? For example, your right to a PAR and your Medicaid Due Process rights?
2. Has your family been notified if there are plans to change your residence? This applies if you live in a CLA, CTH, campus and plans are in place for you to move to another residence. Your family has the right to a transfer hearing if they do not agree with the move.
3. Did your family receive information about how they will be notified in the event there is an incident that occurs while you are being supported? Does your family want to be notified for more than the required incidents? In what instances?
4. Did you receive information about your rights and about self advocacy?
5. Have you received information about how to report suspected abuse or neglect?
6. Have you and/or your family been informed of your priority status if you are on the waiting list, if applicable?
7. Have you received information about your choices of service options to self-direct, use a qualified provider, or use an agency with choice? Do you have any questions about this information? Do you need any additional information?
8. Have you received information about your choice to use an independent support broker if you self-direct?

Notifications and Review (*Check NA for any that do not apply*) Add most current date or check N/A.

PAR Notification (annually at IP)	**Date:**
Medicaid Due Process Rights Notification (annually at IP) ☐ **NA**	**Date:**
Family/Guardian Notification of Incident Reporting Requirements (annually at IP)	**Date:**
Family/Guardian's Incident Reporting Request, Describe if beyond procedural requirements:	
Individual Informed of Human/Civil Rights (annually at IP)	**Date:**
Individual Informed of Abuse & Neglect Information (annually at IP)	**Date:**
Choice of Service Options Discussed (self-directed, vendor, agency with choice) (annually at IP)	**Date:**
Choice of Independent broker to provide FICS (prior to IP for those who self direct) ☐ **NA**	**Date:**
Choice of Vendors/Providers discussed annually	**Date:**
Waiting list Priority Status Notification (annually at IP for those on WL) ☐ **NA**	**Date:**
Transfer Hearing Notification Moving between licensed to licensed residences. Does not apply to transfers initiated by the team in which the person & guardian participated. Revised policy 6/28/2010. ☐ **NA**	**Date:**
Consent Form(s) (at initial visit or if not current) private agencies or ours if needed ☐ **NA**	**Date:**
HIPAA Notification (at initial visit or if not current) Please carry this date year to year Note: If new guardian this needs to be redone along with the waiver form 222. ☐ **NA**	**Date:**
Legal Liability Notification (at initial visit or change of Guardian) Needed for all persons served by our dept. Signed by Parent of minor child, the individual if 18 or over or their spouse if that person is not a member of our dept. ☐ **NA**	**Date:**

Voter Registration Notification (at initial visit, IP, after 17th birthday or new address) ☐ **NA**	**Date:**
PRC Review (Programmatic Review Committee) month/yr next review, Review exemption annually ☐ **NA**	**Date:**
Emergency Fact Sheet and Relocation Form Updated, if applicable. ☐ **Residence** ☐ **Day** ☐ **NA**	**Date:**
Other Notification:	**Date:**
Other Notification:	**Date:**

Emergency Fact Sheets: Are provider's emergency plans and fact sheets updated?

Name:	**DDS#:**
Case Manager:	**Region:** Select
Meeting Date:	**Plan Effective Date:** **to**

IP.2 - Personal Profile

For each profile domain, briefly describe the person's current situation, experiences and issues that will be addressed in the development of the individual plan. Please refer to interview prompt questions for each domain. Include choices, preferences, likes and dislikes, as well as, assistance needed to make decisions in relevant domains.

Important To Know About You:

1. What is most important to know about you?
2. How would you describe yourself?
3. Is there anything about your history or any significant milestones that you would like your planning and support team members to know about you?
4. What past events have been important to you and helped to make you who you are?
5. What is most important to you?
6. What are your preferences and dislikes?
7. Is there anything you would like to change about your life right now?
8. What is important to you about your heritage and ethnic background?
9. Religious preference.

Accomplishments, Strengths and Things You Are Most Proud Of:

1. What are some things you have achieved?
2. What are you good at?
3. What are your strengths and talents?
4. What do you believe you do well?
5. What are your favorite things to do?
6. What have you done, been involved in, or accomplished that you are most proud of and want everyone to know?

Name:	DDS#:

Relationships:

1. Who are the most important people in your life?
2. How do you communicate best with other people?
3. With whom do you like to spend your time?
4. How do you meet new people?
5. Do you have friends you like to talk to and do things with?
6. Would you like to make or have more friends? If yes, what are ways you can meet new people?
7. Are there other people you would like to invite to be on your support team?

Home Life:

1. Where do you live and with whom do you live?
2. Are you happy with your home situation and daily routine?
3. Who decides your daily routine? Are there any changes you would like to make?
4. What is most important to you or do you like most about your home?
5. Do you have any family traditions or cultural preferences?
6. What skills do you have at home? Which ones do you want to develop?
7. What supports do you need to live in your home? In what areas do you need help? How are your support needs being met in your home?
8. What issues did you identify in your assessments, screenings, or Level of Need tool for which you need supports in your home? Are you getting those supports?
9. Did you choose the people who help you at home?
10. Do you feel you're getting the help you need from your support staff?
11. What are your responsibilities at home? Would you like more responsibility?
12. Do you have privacy? Can you be alone if you want to?
13. Do you open your own mail?
14. Can you use the phone when you want to?
15. What do you find most challenging in your home?
16. Are you concerned about your safety in your home or community? Would you like to build in some safeguards?
17. Do you have transportation to get where you need to go?

Please remember:

*To include the individual receiving services, or the guardian's level of satisfaction with the services that are being provided.
*Be sure the identified needs match those in the LON.
*Include the amount of time individual can be left alone from LON.
*If no Emergency Back Up plan is in place document the team reviewed and there is no need for a back up plan.

Name:	DDS#:

Work, Day, Retirement or School:

1. Where do spend your day – school, work, retirement etc?
2. Do you like your job, retirement, school or other activities that you do during the day? What activities do you like best?
3. If you are an adult, do you have a job that is a good fit and pays well? (i.e. real work for real pay)
4. If not, how can you gain experience that could lead to a different job?
5. What is most important to you at work, at school, in your retirement or other activities?
6. What do you find most challenging in your job, at school, or retirement or other day activities?
7. What support do you need at your job, at school, during your retirement or other day activities?
8. Do you receive any natural supports at your job?
9. Did you choose the people who help you at work or during other day activities?
10. Do you feel you're getting the help you need from your support staff?
11. How do you get to work, school, and activities each day? Are you satisfied with your transportation supports? Are their other transportation options you would like to try?
12. As an older adult, are you thinking about retirement and what you would like to do when you retire?
13. Have you reviewed your benefits and/or talked with a Benefits Counselor at BRS?

Please remember:

*To include the individual receiving services, or the guardian's level of satisfaction with the services that are being provided.

*Be sure the identified needs match those in the LON.

Leisure Interests and Community Life:

1. How do you like to spend your free time?
2. What do you consider fun?
3. What activities are you involved in?
4. How are you involved in your community? How do you, or would you like to, contribute to your community?
5. Do you belong to, or wish to belong to, any groups or clubs?
6. Have you ever participated in a self advocacy group? Would you want to?
7. What interests do you have that you would like to explore/expand?
8. Would you like to take classes or learn/increase your skills?
9. What transportation do you use to when participate in activities?
10. What supports do you need to do the things you like to do in your community?
11. Do you have any spiritual interests?
12. What supports do you need to participate in your spiritual community?

Please remember:

*Be sure the identified needs match those in the LON.

Health and Wellness:

1. How would you describe your health?
2. Have you had a physical exam in the last year?
3. Have you seen the dentist in the last six months?
4. Were there specific concerns your doctor wants you to pay attention to?
5. Have you had any incidents this past year related to your health?
6. What supports do you need to maintain good health? Are you getting them?
7. Do you or others who care about you have any concerns about your health?
8. What health issues were identified in your physical exam, health assessments, screenings or Level of Need tool?
9. What supports do you and your support team members need to take care of your health issues?
10. Do you need someone to help you to make medical decisions?
11. Have you had any falls this year?
12. Have you had medical follow-up as a result of any recent falls or new condition?
13. Have you designated some one as a health care representative?

14. Do you want more information about this?
15. Do you require hospice care or have a DNR?
16. Is there any additional information regarding your health you would like to learn about?
17. Would you like information about living wills?

A nursing report can be attached to this section of the plan. The I.P. should contain a summary of the person's health and wellness.
List diagnosis in this section of the plan.
Is there a medical guardian in place?

Name:	DDS#:

1. What current medications are you taking? For what conditions do you take them?
2. Are there any important things to know about this medication?

Medications: Please list an overview of the nurse's report.
List Current medications including Over the Counter (OTC) medications. Don't forget the OTC medication. Dose not required.

Type:	Reason for Medication/Comments:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.
13.	13.

If there are any medications, how are they stored. Does the individuals require assistance to take medications?

Adaptive Devices (if applicable):

1. Are you in need of any adaptive equipment or accommodations?
2. Is it available to you when you need it?
3. Are your support staff trained to help you to use your adaptive equipment?
4. Is there an adaptive equipment plan that describes when and how to use your adaptive equipment?
5. Is it properly maintained?
6. Are there any other accommodations that you would like to receive at home, work or while in the community?

If there are any modifications that address behavioral issues they should also be listed. Alarms, locks, seat belt harness.

Finances:

1. What are your sources of income? (Note: Include the amounts of income in the Information Profile, IP.1, Resource and Benefit Information section.)
2. Do you need support to manage your money and other benefits?
3. Are there areas of managing your funds that you would like to develop or strengthen?
4. If you need assistance, who helps you or would you like to help you manage your finances?
5. Do you have sufficient money to support your needs?
6. Do your resources meet your needs?
7. Do you choose what you buy with your spending money?
8. In what ways could you increase your skills in making purchases or paying your bills?
9. Have you applied for all the entitlements for which you may be eligible?
10. Have you kept current with Medicaid and other entitlements and benefits?
11. If you want to make a major purchase, do you have a plan to save money?
12. Have you looked at a special needs trust for yourself? Asset planning?
13. Have you thought about a retirement fund?
14. Have you thought about funeral plans or a burial fund? Who would be the best person to talk to you about funeral

plans?

15. Do you have any concerns about your benefits? Do you need a benefits check-up completed?
16. Should you consider contacting a benefits specialist to help understand the impact of employment on your benefits as part of your overall financial management planning strategy?

Did the LON identify a risk in this area? If so, needs to have mention in the action plan.
Is assistance needed and if so, who assists with finances? **(Action step needs to be included in the plan as to what Financial assistance will be offered.)**
Who completes re-determination forms?

List any burial plans the individual has.

Name:	**DDS#:**

IP.3 - Future Vision

What are your hopes and dreams for the future (one to three years?)

1. What would you like your life to look like in three years?
2. Where would you like to live, work, spend your day, spend your free time?
3. What supports do you believe you need?
4. Who would you have in your life?

This is a dream. It does not have to be realistic. Pieces of this dream may be obtainable and be beneficial to the individual. The action step should contain a step toward this 3 year plan. This should be the goal of the person, not an agency.

What do you hope to accomplish in the coming year?

Be certain to build an action step to address these desires. This area is more specific. Is there anything that you can do this year to address a future vision? This should not be a repeat of the Action Plan. Some of these goals may be a part of an Action Step.

1. Where do you see yourself in one year?
2. What do you hope to accomplish:
   a. At home?
   b. At work or at school, during retirement or during any other times during the day?
   c. For fun or leisure?
   d. In your community?
   e. With relationships?
   f. With your money?
3. Do you have any personal goals around your health and safety? career outcomes? self-advocacy?
4. What additional supports do you believe you will need this coming year?

Name:	DDS#:

IP.4 Assessments, Screenings, Evaluations and Reports

What current assessment, screenings, evaluations or reports information is available to help you plan for your future? Indicate if assessments, screenings, evaluations or reports are current, needed or not applicable.

Assessments, Screenings, Evaluation Report:	Current	Needed	N/A
▪ Physical Exam	☐	☐	☐
▪ Self-Medication	☐	☐	☐
▪ Dental Exam	☐	☐	☐
▪ Gynecological Exam	☐	☐	☐
▪ Mammogram	☐	☐	☐
▪ Other Health/Medical:	☐	☐	☐
▪ Level of Need Assessment & Screening Tool	☐	☐	☐
▪ My Health and Safety Screening (Optional)	☐	☐	☐
▪ Speech & Language /Communications	☐	☐	☐
▪ Physical Therapy	☐	☐	☐
▪ Occupational Therapy	☐	☐	☐
▪ Assistive Technology	☐	☐	☐
▪ Nutrition/Dietary	☐	☐	☐
▪ Behavior	☐	☐	☐
▪ Psychological	☐	☐	☐
▪ Psychiatric	☐	☐	☐
▪ Neurological	☐	☐	☐
▪ Other Clinical:	☐	☐	☐
▪ ADL	☐	☐	☐
▪ Aquatic Activity Screening (Required)	☐	☐	☐
▪ Bed & Safety Rail Audit	☐	☐	☐
▪ Vocational/Day	☐	☐	☐
▪ Guardianship	☐	☐	☐
▪ Resource/Financial (ex. Benefit Checkup)	☐	☐	☐
▪ Level of Support and Supervision	☐	☐	☐
▪ Waiting List Priority Checklist	☐	☐	☐
▪ Respite Profile Information	☐	☐	☐
▪ IHS Nursing Health and Safety Assessment	☐	☐	☐
▪ IHS DDS Life Skills Assessment	☐	☐	☐
▪ IHS Self Medication Form	☐	☐	☐
▪ Aging Assessments (Falls, Dementia)	☐	☐	☐
▪ Other:	☐	☐	☐
▪ Other:	☐	☐	☐

Comments: **An action step needs to be developed for any needed assessment, notes in the comment section do not suffice**. Any identified needed assessment should be completed within 3 months of the plan development. If there is an immediate risk, it should be addressed immediately. Needed assessments and recommendations from completed assessment need to be reviewed by the team and if necessary, built into an action step.

If the service providers do not submit progress reports, please document as needed and write an action step to address it.

What current assessments are available?

1. What important information do these assessments tell about you?
2. What should planning and support team members know about these assessments?
3. What important support needs are identified in these assessments?
4. What are the risk areas identified on the LON Summary Report?
5. Are there supports that must be available to keep you healthy and safe?
6. Are the needed supports in place and adequate?

7. What additional information would be important to know about you?
8. What additional assessments, screenings, evaluations, or reports are needed to gather this information? Be sure to include any that are needed in the Action Plan, IP.5.
9. Are there any age related assessments in areas such as Falls, or Dementia that are needed?

IP. 5 Action Plan

Name:	**DDS#**

IP.5 - Action Plan

Now that you have reviewed the personal profile, Level of Need, LON summary report, all assessments, and future vision, Please develop an action plan to address all areas identified.

***We have individuals with complex needs and issues. The supports that are provided, or that the team feels the person needs, should all be listed here. These are the supports the person is to receive this year. This is what the agency and others agree to provide.**

1) Any need an individual has that warrants a protocol, guideline, program, needs to be in the action plan.
2) All supports (waivered services, state funded, Medicaid state plan home health care including respite and Family Support Services) need to have an action step.
3) Identified risk areas in the LON summary need to be addressed in the plan either in the Action Plan Section or in The Profile Section.

Issues or Needs (Why is this Important? Current Status?)	**Desired Outcome** (What Do You Hope to Accomplish?)	**Actions and Steps** **Should be measurable.**	**Responsible Person(s)**	***By When***
1. What is the current situation, identified need, individual's desire. Say what you mean, don't use generalities.	1. What does the individual want to accomplish this year?	**1A: List the steps you will take to address this desired outcome. Depending on the outcome this could be detailed or could** reference any service plans, protocols, guidelines, behavior plans, health care plans,steps. If an agency is providing a support it needs be listed in the plan.	Who is going to make this happen? What is the individual's role in their plan?	Daily, weekly, monthly, 1/4ly, or completion date.
		1B:		
		1C		
		1D: :		
		1E:		

Issues or Needs (Why is this Important? Current Status?)	**Desired Outcome** (What Do You Hope to Accomplish?)	**Actions and Steps**	**Responsible Person(s)**	***By When***
2.	2.	**2A:**		
		2B:		
		2C:		
		2D:		
		2E:		

Issues or Needs (Why is this Important? Current Status?)	**Desired Outcome** (What Do You Hope to Accomplish?)	**Actions and Steps**	**Responsible Person(s)**	***By When***
3.	3.	**3A:**		
		3B:		
		3C:		
		3D:		
		3E:		

Name:	**DDS#**

Issues or Needs (Why is this Important? Current Status?)	**Desired Outcome** (What Do You Hope to Accomplish?)	**Actions and Steps**	**Responsible Person(s)**	***By When***
4.	4.	**4A:**		
		4B:		
		4C:		
		4D:		

Issues or Needs (Why is this Important? Current Status?)	**Desired Outcome** (What Do You Hope to Accomplish?)	**Actions and Steps**	**Responsible Person(s)**	***By When***
5.	5.	**5A:**		
		5B:		
		5C:		
		5D:		

Issues or Needs (Why is this Important? Current Status?)	**Desired Outcome** (What Do You Hope to Accomplish?)	**Actions and Steps**	**Responsible Person(s)**	***By When***
6.	6.	**6A:**		
		6B:		
		6C:		
		6D:		

Issues or Needs (Why is this Important? Current Status?)	**Desired Outcome** (What Do You Hope to Accomplish?)	**Action and Steps**	**Responsible Person(s)**	***By When***
7.	7.	**7A:**		
		7B:		
		7C:		
		7D:		

Name:	DDS#
Date:	

IP.6 - Summary of Supports and Services

1. What are the waiver, state funded, generic, and informal supports and services that will be provided to you?
2. Who are the agency vendors or individuals who will provide the supports?
3. What types of support or service will they provide? If these are supports funded by one of the DDS HCBS waivers, please be sure to include the name of the waiver service.
4. What is the amount of supports and services that will be provided and how often will they be provided? For instance, how many hours per week or times per month will you receive the supports?

Each waivered service must be listed here and must be crossed referenced in an action step. This needs to include both waivered and state funded services.

Agency/individual/Vendor	***Type of Support/Service*** *(specify type of HCBS Waiver Services and include non-waiver supports and services)*	***Amount of Support/Service*** *Hours per Week/Month/Year*
Needs to match agency identified in the budget. If modification is made need to modify the plan to match the individual budget.	Don't forget transportation.	Needs to match the budget. CLAs are on master contract and should be listed as 24/7.
	If the same agency provides 2 waivered services, you must list both services under the type of Support/Services section. (You should have a separate line for each service provided.)	
Each budget line item needs to be identified individually.		
No individual agency personnel need to be listed as they are included under the agency's name. The exception would be if the person was contracted for a specific service outside of their agency duties.		
Case Manager/Support Broker	Case Management	1/4ly and as needed

Date:	

1. Each Waiver service identifies standard qualifications that employee(s) who support you must have. What are the basic requirements for staff who provide your supports?
2. Are there any additional or specific qualifications (expertise, competence, and or training) that staff should possess to effectively support you?

IP.7 – Provider Qualifications & Training

DDS Waiver Services to be Provided (please check all that apply):

☐	**Comp – Individualized Home Support or CRS**	☐	**Group Day Supports (includes DSO)**
☐	**Comp – Residential Habilitation (CLA & CTH)**	☐	**Individualized Day Supports**
☐	**Comp – Assisted Living**	☐	**Supported Employment - Individual**
☐	**IFS – Individualized Home Support or CRS**	☐	**Supported Employment - Group**
☐	**IFS – Residential Habilitation (CTH)**	☐	**Adult Day Health Services**
☐	**IFS – Family Training**	☐	**Respite**
☐	**Personal Support**	☐	**Nutrition**
☐	**Adult Companion Services**	☐	**Interpreter Services**
☐	**Health Care Coordination**	☐	**Transportation**
☐	**Clinical Behavioral Support Services**	☐	**Independent Support Broker**

Each Waivered service checked above must have a qualification box below filled in.

DDS Waiver Service: Select

☐ **No, additional qualifications are required**
☐ **Yes, the following additional qualifications are required**

Additional or Specific Qualification(s) (Specialized Expertise and or Training) **Specific Programs need to be noted not a general statement.**	**Timeframe in which the Qualification(s) Must be Met (X)**	
	Prior to working Alone	**Within 30 days**
	☒	☐
	☒	☐
Client specific health and safety programs/guidelines/protocols (copies need to be available)	☐	☐
Ex: food consistency, feeding plans, behavioral plans, OT/PT support plans, seizure protocol.	☐	☐
	☐	☐

DDS Waiver Service: **Select**

☐ **No, additional qualifications are required**
☐ **Yes, the following additional qualifications are required**

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	**Timeframe in which the Qualification(s) Must be Met (X)**	
	Prior to working Alone	**Within 30 days**
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

IP.8 - Emergency Back-Up Plan

1. Do you live in your own or family home?
2. Do you receive personal care or other supports that must be available as described in the Individual Plan or it would lead to an immediate risk to your health or safety?
3. What are the specific back up plans that should be followed in the event that needed supports are not available?

This form is to be completed for individuals who receive waiver services and live in their own home, family home or other settings where staff might not be continuously available, and who receive ***personal care and/or supervision supports*** and the failure of those supports to be available would lead to an immediate risk to the individual's health and/or safety.

If No: Document in the Home Life section of the I.P. that the team discussed, and No plan is needed.

☐ **No Emergency Back-up Support Plan is Required**
☐ **Yes, an Emergency Back-up Support Plan is Required and Described Below:**

Type of Personal Care or Supervision Support Provided	Agency (A) or Self-Directed (SD) Supports		Name of Emergency Contact Person	Telephone Number of Emergency Contact Person	Specific Protocols
	A	SD			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

Name:	DDS#:

IP.9 - Summary of Representation, Participation & Plan Monitoring

Choice and Decision Making

Planning and Support Team review an assessment of a person's understanding and capacity to make important decisions/choices, accept assistance from others and possible need for guardian/advocate/legal or personal representative.

Does This Person Need A Guardian?

1. What support and assistance do you need or rely upon to make informed choices and decisions?
2. On whom do you rely for support and assistance in decision-making?
3. Do you have, need, or want a guardian for assistance and support?
4. What information, support, and assistance do you need to make informed choices and decisions in your best interest?

Individual's Participation in Planning Process

Summary of team's efforts to involve the person in planning, the person's actual participation in the planning process, and planned efforts to enhance the person's future participation in planning.

1. How were you involved in preparing for and participating in your planning meeting?
2. Were there any ground rules you established for your meeting? Any there ground rules you want to be sure are followed in the future?
3. Were you prepared to say what you wanted to say at your meeting? How could you be better prepared for the next meeting?
4. What supports did you receive to effectively communicate your thoughts?
5. What supports will help you to successfully advocate for yourself in the future if others do not agree with you?
6. Is there anything else that is needed to help you prepare for your next planning meeting?
7. Individual should attend their planning meeting. If they were not in attendance, what is the plan to involve them next year as well as what efforts were made this year to obtain their input. What could assist them in participating more fully next year.

Representative's Participation in Planning Process

Summary of the team's efforts to involve the person's family/guardian/advocate/legal or personal representative in the planning process, the actual participation of these individuals in the process, and planned efforts to involve these individuals in planning in the future.

Who is the individual's PRP?

1. How were your representatives including family, guardian or advocate involved in preparing for and participating in your planning meeting?
2. Are there any supports your representatives need to participate more effectively in the future?
3. Guardian's schedule should be considered when planning meetings.

Summary of Monitoring and Evaluation of the Plan

Summary of the team's efforts to ensure that the plan is being implemented and that progress is being made toward desired outcomes.

This section must include statements which are written below in Red.

1. The Service providers will forward progress reports documenting progress on the action plan to all team members at 6 month intervals. The team will receive the report for the planning meeting 2 weeks prior to the meeting being held.
2. The case manager will provide 1/4ly contact and other contact as needed.
3. If the case manager wished to document when QSR's will be conducted this can be done here.

Name:	Region:Select	DDS#
Case Manager:	Plan Date:	

IP.10 – HCBS Re-determination

1. Do you have needs that can be met through waiver services so you do not have to live in an institution (ICF/MR) or in a Nursing Home to have your support needs met?
2. Do you and you team feel that but for the provision of waiver services you would need services in an ICF/MR or Nursing Home?
3. Do you require supports and help to perform and learn self care and daily activities?
4. Was the Waiver Redetermination done within 365 days of the last one?

There is reasonable indication that the person, but for the provision of waiver services would in an ICF/MR. [42CFR441.302(c)]

Appropriate boxes must be checked.

The person requires assistance due to the following (check at least one):

- ☐ Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative training in performing self-care and daily activities
- ☐ Has a deficit in self-care and daily living skills requiring habilitative training
- ☐ Has a maladaptive social and/or interpersonal behavior patterns to the extent that he/she is incapable of conducting self-care or activities of daily living without habilitative training

This determination was made through a planning and support team process based on comprehensive professional assessments, evaluations, and/or reports that are on file in the:

- ☐ Case Record; or
- ☐ Other Location (identify)"

Signature: _____ **Title (QMRP):**

State of Connecticut
Department of Developmental Services
Individual Plan

Name:	DDS#	Meeting Date:	☐ Plan Development ☐ Periodic Review ☐ Other

IP.11 - Individual Plan Signature Sheet

1. Who attended your planning meeting?
2. Who participated in the planning process?
3. After a review of the completed plan, do you agree with it? If not, please notify your case manager within 2 weeks of receipt of the plan.
4. After a review of the completed plan, does your family or guardian agree with it? If not, they should notify your case manager within 2 weeks of receipt of the plan.

Name	Signature	Relationship To The Person	Attended Meeting (x)
The individual should sign in any manner if at all possible. Their name would definitely be listed and staff may need to do that for them.	**MUST HAVE SIGNATURES**	**Individual**	☐
		Family Member/Guardian	☐
		Advocate (as applicable)	☐
		Case Manager	☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

As a consumer, family member, guardian or advocate, please contact your case manager within two weeks of receipt if you do not agree with this plan as written.

As a consumer, family member, guardian or advocate, you have the right to request a Programmatic Administrative Review pursuant to Policy DDS-7, if you disagree with any portion of the plan.

THIS FORM WILL BE TYPED AND ELECTRONICALLLY SENT TO TEAM MEMBERS. ORIGNAL SIGNATURE SHEET WILL REMAIN IN THE DDS RECORD.

State of Connecticut
Department of Developmental Services
Individual Plan

IP Addendum: Aquatic Activity Screening

Name:	DDS#:	Date:

This screening is in effect for one year from the date on this form as part of the IP or up to three years for individuals with an IP Short Form. Request for any changes or updates to this form must be made through the team process.

SECTION 1: Screening For Presence And Participation in Aquatic Activities

Definitions:

Aquatic Activities: are all water related activities including swimming, boating, fishing, hot tubs, water parks and those activities PROXIMAL TO WATER.

Proximal To Water: aquatic activities are those at any location where there are bodies of water present at the intended destination that are open and accessible to individuals. This means there are no barriers to prevent access such as secure fencing or padlocked gates. Contact with the water may, or may not be intended. Bodies of water include, but are not limited to: streams, creeks, oceans, lakes, ponds, pools, hot tubs, wading pools, natural or man-made water areas or similar. Proximal to water activities include, but are not limited to: picnics in a park where there is water, feeding the ducks at a pond, unrestricted access to backyard wading (or swimming) pools or hot tubs, walks on the beach or similar.

Shallow Water: is defined as water at or below the height of the individual's chest.

Deep Water: is defined as water above the height of the individual's chest.

The Planning and Support Team should assign an Aquatic Activity Code "0 to 6 "for the individual

Aquatic Activity Code:

- ☐ **0 = Does NOT** swim or participate in **ANY** aquatic activities. **If coded as "0", Section 2 should have "NO" checked for all activities listed.**
- ☐ **1 = Proximal to Water Activities Only – Must Be With Staff.** Participates only in activities proximal to water as defined above.
- ☐ **2 = Shallow Water Only**; limited or no swimming skills. **Does Not Respond** to verbal redirection; may not recognize dangerous situations.
- ☐ **3 = Shallow Water Only**; limited or no swimming skills. **Usually Responds** to verbal redirection; may/may not recognize dangerous situations.
- ☐ **4 = Deep Water** swimmer; can swim in deep water **with supervising staff**; may have medical or safety needs
- ☐ **5 = Independent Deep Water Swimmer;** may go swimming without staff; ***AND/OR*** **independently accesses aquatic activities without staff;** may not, or chooses not, to swim. The Water Safety Checklist shall be reviewed annually with the individual to encourage safe aquatic activity participation.
- ☐ **6 = Aquatic Activity Level Not Known.** Approved only for aquatic activities as permitted below and MUST BE IN A ONE-TO-ONE enhanced individual to staff ratio at all of these activities until code is determined and approved.

SECTION 2: Aquatic Activities and Supervision Needs – Include Staff to Individual Ratio as Appropriate

NOTE: If supervision needs are unknown due to lack of previous participation, the individual must be in a 1:1 enhanced staff to individual ratio at all aquatic activities they are able to participate in, until a safe appropriate ratio can be determined and approved.

AQUATIC ACTIVITY	ABLE TO *PARTICIPATE*	INDIVIDUAL SUPERVISION NEEDS	COMMENTS (needs lifejacket, medical information, etc.)
Activities Proximal to Water	☐ **yes** ☐ **no**	# staff to # individuals	
Shore fishing	☐ **yes** ☐ **no**	# staff to # individuals	
Boating	☐ **yes** ☐ **no**	# staff to # individuals	**Lifejacket mandatory for all.**
Swimming	☐ **yes** ☐ **no**	# staff to # individuals	
Water Parks	☐ **yes** ☐ **no**	# staff to # individuals	
Hot Tub Use **(Doctor's Order required for "YES")**	☐ **yes** ☐ **no**	# staff to # individuals	
Ice Skating (ponds & lakes only)	☐ **yes** ☐ **no**	# staff to # individuals	
Able to access aquatic activities independent of staff supervision	☐ **yes** ☐ **no**	**If 'yes' is checked, the individual may only have an aquatic activity code of #5**	**If 'yes' is checked, Water Safety Checklist has to be reviewed with the individual by staff every year between March 1st & May 1st**